Physicians' newsletter

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New Initiative for Effective Care of Chronic Kidney Disease – Another CDM Success Story

With the leadership of the BC Renal Agency, the province's health care community has worked together over the past year on a major initiative designed to reduce the risks of end-stage renal disease and unrecognized impaired kidney function.

"The statistics are disturbing," explains Dr. Adeera Levin, Director of the BC Renal Agency. "We're seeing the emergence of an end-stage renal disease (ESRD) epidemic worldwide, and BC is no exception. Unless we do something now, a huge wave of new ESRD cases will be hitting our health care system in the next few years. Improved early identification and appropriate treatment of chronic kidney disease (CKD) is key to reducing this significant pressure on an already over-burdened system."

BC's new evidence-based initiative focuses on improving identification, evaluation and management of patients with chronic kidney disease.

Many people with chronic kidney disease remain undiagnosed or do not receive appropriate treatment simply due to problems inherent in serum creatinine measurement, the standard blood test for assessing kidney function.

"This test is not sensitive to early kidney damage unless a complex table of age and gender specific reference ranges is used," explains Dr. Michael McNeely, Chairman of the Chemistry Science Section of the BC Association of Laboratory Physicians. "In addition, it is difficult to identify the patient's stage of kidney disease based on their serum creatinine results."

The glomerular filtration rate (GFR) is widely accepted as the best overall measure of kidney function. Equations have been developed that use the patient's serum creatinine, age and gender to provide a mathematical estimate of the true glomerular filtration rate. The estimated GFR (eGFR) provides a standardized measure that is easy to interpret and allows for the staging of kidney disease.

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BC Health Services

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Effective Care of Chronic Kidney Disease

The Chemistry Science Section of the BC Association of Laboratory Physicians has coordinated a project that will see all provincial laboratories providing an eGFR whenever a serum creatinine is ordered for an adult outpatient. In addition, all laboratories will soon be standardizing their serum creatinine measures and their eGFRs.

"BC is the first geographic area in North America to report the eGFR, and the first time anywhere to standardize its serum creatinine measurements," notes Dr. McNeely.

Progression of chronic kidney disease to end-stage renal disease usually takes several years. Through lab reporting of eGFR, BC physicians will be better able to evaluate kidney function and provide appropriate, often simple treatment, at the stage when it will be most effective. "It is important to appreciate that patients with impaired kidney function are at higher risk of cardiovascular disease and the potential consequences of improper drug dosing," notes Dr. Levin. "Using eGFR to detect reduced kidney function will also help physicians and patients ensure that appropriate drug dosing and testing are undertaken."

To help support family physicians and specialists in assessing and treating patients, evidence-based standards of care will soon be available. A new BC clinical practice guideline, *Identification, Evaluation and Management of Patients with Chronic Kidney Disease*, has been developed through the MSP/BCMA Guidelines and Protocols Advisory Committee. This guideline dispels the common belief that very little can be done to slow or prevent the onset of end-stage renal disease by assisting health professionals to better understand the stages of chronic kidney disease. It also highlights opportunities to improve health outcomes for patients through, for example, the use of ACE inhibitors, optimal control of glucose levels, and timely involvement of specialized nephrology teams.

"Treatment of chronic disease is rapidly becoming the cornerstone of family practice," comments Dr. Bill Cavers, General Practitioner, Chronic Kidney Disease Guideline Working Group. "This guideline provides a valuable tool to better coordinate patient care, and to slow or arrest the progression of kidney disease. It has the potential to improve the quality of life for thousands of our patients in this province."

In support of BC's family doctors and patients with chronic kidney disease, renal programs throughout the province have pioneered the development of clinics to assist in patient education, self-management and medical care.

"Early experience strongly suggests that these clinics are performing as expected to slow progression, prevent complications, and delay the need for dialysis in patients with chronic kidney disease," says Dr. Gerry Karr, Nephrologist on the Chronic Kidney Disease Guideline Working Group, and key initiator of the Penticton clinic.

"The demand for dialysis services in BC is expected to increase by eight to ten per cent annually if early kidney disease detection and treatment do not improve," comments Dr. Levin. "In addition to supporting practitioners, we also need to raise awareness about kidney disease among patients."

To help raise awareness, a patient information website on kidney disease has been developed by the Ministry of Health Services. This website describes risk factors, the importance of early detection and treatment, medical intervention, and lifestyle changes aimed at slowing or stopping the progress of kidney disease. A companion patient information guide is also available to practitioners and patients as part of BC's clinical guideline for kidney disease.

Early detection and treatment of kidney disease will also be assisted by a new patient register, jointly developed by the BC Renal Agency and the BC Ministry of Health Services. It will help identify and track patients at all stages of chronic kidney disease, including at-risk populations, through analysis of existing Ministry administrative data.

"The BC Chronic Kidney Disease Initiative is a very comprehensive strategy," comments Dr. Levin. "We'll learn more about what is working well and where improvements are needed as practitioners begin incorporating the components into their clinical process."

For more information, e-mail: hlth.cdm@gems1.gov.bc.ca

To read about other CDM success stories visit our Web site:

www.healthservices.gov.bc.ca/cdm/success/index.html

New and Modified Explanatory Codes

JG - Services for pain control/ acute pain control are included in Critical Care fees for ventilatory support and/or comprehensive care.

MP - Fee item 00109 is not applicable when a patient is admitted for surgery. The appropriate visit fee has been paid.

MQ - Fee item 00109 is not applicable when a patient is referred for continuing care by a certified specialist. The appropriate visit fee has been paid.

MR - Fee item 00109 is not applicable when preceded by a complete physical exam within 7 days by the same physician. The appropriate visit fee has been paid.

NA - Payable at 50% when billed with delivery fees.

NB - Fee item 14094 is only payable following a vaginal delivery.

QZ - 77043 is only paid with applicable vascular surgery items.

Updated explanatory codes:

ID - Claims for 00081 must be supported with details of bedside/ resuscitative services. Please provide break down on a per ½ hour basis.

JP - Critical Care ventilatory support (01412 - 01442) has been paid to another physician. Your claim has been paid/refused according to the Section Preamble.

JR - Critical Care (01411 - 01441) has been paid to another physician. Your claim has been paid/refused according to the Section Preamble.

Reworded explanatory codes:

KJ - The total number of services exceeds the number of hospital days.

QQ - 07043/77043 is not applicable according to the information provided.

BILLING TIPS

Fee Item 01202

Fee item 01202 is not applicable for routine care provided on the weekend. This is a call-out fee and all criteria in the Out-of-Office Hours Premiums section of the Payment Schedule must be met in order to bill this item.

Reminder - Fee items 00334 – 00336 - Graded exercise test

In order for a repeat service to be billed for the same patient within a year, a note record must be provided indicating the medical necessity for the repeat service. This applies when billed with fee item 08662 (Exercise echocardiography with pre and post-exercise echocardiogram of left ventricle with use of continuous loop and quad screen format analysis). When the exercise stress test (00334, 00335, 00336) and exercise echocardiogram (08662) are performed by the same physician, the stress test will be paid at 50 percent. A note record indicating "stress echo" is not sufficient medical necessity.

Revised Requisition Form

Enclosed with the newsletter is a copy of the revised Standard Out-Patient Laboratory Requisition Form. The requisition form now includes a section regarding the non-nominal report option for HIV testing.

For more information please refer to the letter from the Provincial Health Officer and the College of Physicians and Surgeons included with this newsletter.

General Practice/Emergency Department

As a result of a complaint and subsequent service verification audit, the Audit and Inspection Committee recommended an on-site audit be done on this practice, which included on-call services in an Emergency Department.

Inappropriate MSP billings were revealed in four areas:

1) complete examinations rendered in the Emergency Department which were not medically necessary or did not meet *Payment Schedule* criteria, which require a complete physical examination of all systems and must be recorded in an adequate medical record;
2) day-time emergency visits (fee item 00112) in non-emergent situations such as assistance at pre-booked surgery;
3) counselling visits, which did not involve significant emotional distress, or a difficult medical problem; and
4) out-of-office hours premiums, which did not qualify under the *Payment Schedule* criteria.

The physician agreed to repay the Commission $40,000 inclusive of audit costs and interest, and abide by a *Patterns of Practice Order* in all future billings of this nature.

General Practice

An MSC audit revealed various inappropriate billing practices by a general practitioner. Issues identified through the audit were:

1. billing for uninsured routine or periodic physical examinations;
2. inadequate or missing clinical records;
3. billing nursing home visits where the visits were not medically necessary;
4. billing for "no shows"; and
5. billing fee item 00100 (office visit) for intra-muscular injections.

The recovery proceedings were stayed after the physician began proceedings under the *Bankruptcy and Insolvency Act*. The physician, however, has consented to a *Patterns of Practice Order* and may be subject to a de-enrollment for any future breach of the Order.

General Practice

The Medical Services Commission recently arrived at a negotiated settlement agreement with a general practitioner in a dispute about patterns of practice and billing.

At issue were the following billings:

1) 00100 series office visits when the sole purpose of the visits was to provide an uninsured refill prescription.
2) 00101 series complete examinations where such examinations were either incomplete, unnecessary or inadequately documented in the medical record and therefore should otherwise have been billed as a 00100 series office visit.
3) 00100 series office visits when the sole purpose of the visits was for injection of medications.
4) 00120 series counselling as a substitute for 00100 series office visits, where assessment and/or treatment of multiple complaints resulted in detention beyond 20 minutes.

As a result, the physician has agreed to repay a total of $40,000 inclusive of recovery, audit costs and statutory interest and surcharge. The practitioner has also agreed to adhere to a *Patterns of Practice Order*.
The Commission will continue to monitor the practice to insure compliance with the directive.

Obstetrics and Gynecology

As a result of a service verification audit, the Audit and Inspection Committee recommended an on-site audit be done on this physician's practice. The audit was focused on claims for "emergency visits when specially called" (fee item 04005).

The physician acknowledged the inappropriate billing of fee item 04005 and agreed to reimburse the MSC for $21,250 inclusive of surcharge and interest costs. In this case, the physician readily acknowledged having misinterpreted the Schedule and the matter was resolved without the necessity of an on-site audit. The physician also signed a *Patterns of Practice Order* agreeing to comply with the *MSC Payment Schedule* in future.

Orthopedics

The Commission was alerted to possible inappropriate billings in an orthopedic practice by an anonymous complaint. A review of the surgeon's billing profiles revealed unusual statistical measures consistent with the allegations.

The audit was ordered by the Audit and Inspection Committee and raised the following concerns:

1) the surgeon appeared to claim a total synovectomy, knee, when only a debridement was performed
2) many consultation claims did not meet MSP criteria e.g. not supported by a written report, billed on or within 41 days of the operation, or billed within 6 months of the last consultation

The medical inspector (an orthopedic surgeon) also noted an unusual ratio of complex to simple procedures for fee items unrelated to the original complaint. Review of the relevant medical records found:

1) 10 cases where the surgeon billed for a subtrochanteric ORIF, when apparently an interochanteric ORIF was performed;
2) 28 cases where the surgeon billed for a complex rotator cuff reconstruction when only a repair procedure was performed;
3) 3 cases where the surgeon billed a proximal femoral replacement when apparently only a revision of the femur or acetabulum was performed;
4) 13 cases where the surgeon billed a bilateral ankle fracture ORIF when only a unilateral ORIF was performed.

As a result of a negotiated settlement, the surgeon agreed to reimburse the Commission $76,000, inclusive of costs, interest and surcharge, and abide by a *Patterns of Practice Order*. The Commission will continue to monitor this surgeon's future billings.

Psychiatry

The continuation of payment of specialist fees beyond six months duration requires re-referral by another physician.

An audit of a psychiatric practice showed, among other things, that the necessary re-referrals were frequently not documented. As the result of a negotiated settlement, the psychiatrist agreed to repay the Commission approximately $16,000 for services, audit costs and interest and abide by a *Patterns of Practice Order* in which claims for specialist visits comply with Schedule criteria, especially in respect to documentary proof of re-referral and adequate record-keeping.

Continued on page 6

... *Continued from page 5*

Dr. Raymond C. Penner, General Practice - North Vancouver, BC

A previous audit of Dr. Penner in 1991 found an inappropriately high rate of billings for complete physical examinations (00101) and counselling (00120) which resulted in a negotiated settlement, wherein he agreed to repay the Commission $95,000.

The Commission continued to monitor his practice and a subsequent audit in 2001 was ordered because of continued high billing rates for counselling and complete examinations. Audit confirmed that claims for complete examinations and counselling, in lieu of lesser office visit codes, were either medically unnecessary or not substantiated by adequate medical records.

A negotiated settlement with the Commission was again reached in which Dr. Penner agreed to:

a) repay $130,000 to the Commission, inclusive of costs, interest and surcharge;
b) keep adequate medical records;
c) claim complete physical examinations and counselling only in accordance with the *MSC Payment Schedule*;
d) abide by a *Patterns of Practice Order* in which complete physical examinations or counselling fees may be claimed only up to the average annual rate for general practitioners. If the average rate is exceeded, then the excess dollar amount will be repaid to the Commission.

The Commission will closely monitor Dr. Penner's billing profile to ensure compliance with the settlement agreement and the *Patterns of Practice Order*.

Annual Complete Physical Examinations

In British Columbia, a routine annual complete physical examination has never been an insured benefit when performed without a valid medical requirement. The governing legislation of MSP, the *Medicare Protection Act* and Regulations, requires that coverage is available only for those services that are considered to be medically necessary. British Columbia bases its policy of not insuring routine annual physical examinations on the findings of the Canadian Task Force on Periodic Health Examination.

Annual complete physicals have not been found to improve health outcomes through early detection to the extent that they would be a prudent use of public funds.

Targeted early detection strategies are encouraged in the context of medical office visits. For example, the British Columbia Cancer Agency recommends periodic Pap smears as appropriate care for women in specific age groups, and MSP provides coverage for these and other screening tests that have been identified as medically beneficial.

Patients are free to request their physicians perform annual physical examinations. MSP, however, can only provide coverage when the examination is medically required for the management of health issues. Therefore, if a patient attends a physician with specific symptoms or for monitoring of a known medical condition under treatment, MSP will pay for the visit.

MSP BULLETIN SPRING/SUMMER 2004

The Medical Services Plan's Bulletin is provided to help physicians identify patients whose MSP benefits have payment restrictions. This Bulletin provides important billing information for physicians only. Thank you for respecting the confidential nature of this information.

The Bulletin is an updated listing of restricted MSP enrollment numbers for clients who have signed a legal *Agreement of Limitation* form which limits MSP payment responsibilities to one primary care physician. If care is provided by other physicians, the charges must be made directly to the clients. MSP will not accept payment responsibility unless special circumstances are clearly stated. An example of this would be medical care that has been provided by an emergency physician in the hospital emergency room.

MSP is concerned about the potential misuse of CareCards and strongly recommends a complete check of CareCard information at all first appointments. If you suspect any unusual use of a CareCard, please request a second piece of picture identification in order to verify that the CareCard is being presented by the person named on the card.

PHN	Birthdate (MM/YY)	Sex M/F	Physician Number
9013676868	12/54	M	06541
9023967395	02/54	F	03023
9025293026	12/58	M	24287
9029287062	06/52	F	06061
9029596344	09/55	M	00792
9030165823	12/54	F	05334
9030205973	05/54	M	26411
9030780581	05/29	F	08241
9030861738	10/45	M	01604
9032398914	08/56	M	09760
9032842679	05/59	F	01229
9034248181	10/59	F	07834
9034793801	06/59	F	06468
9035294522	07/58	M	23759
9041726364	07/56	F	03733
9071584167	06/48	M	09604
9104870848	04/67	F	09443
9107346403	08/54	M	08365

UPDATE

The Full Service Family Practice Incentive Program
(Effective September 1, 2003)

This is a Joint Initiative of the BC Ministry of Health Services, BC Medical Association and the Society of General Practitioners of BC

Longitudinal full-service family practice is the cornerstone of good patient-centered care. In recognition of this, and in response to some of the challenges they are currently facing, BC family physicians can choose to access any of the following financial incentives (funded through a 2-year, $20 million allocation for family physician services set aside under the Subsidiary Agreement for General Practitioners-November 2002):

1. Obstetrical Care Incentive Payment To Support Low-Moderate Volume Delivery ($3 million): General practitioners performing only one delivery per day can receive a 50% bonus payment on top of the MSC Payment Schedule delivery fee items 14104 or 14109 for one delivery per day, up to a maximum of 25 deliveries per calendar year.

2. Chronic Care Practice Enhancement Pilot Project ($15.5 million): Full service family practice physicians can receive an annual $75 incentive payment for each patient with a confirmed diagnosis of diabetes mellitus or congestive heart failure whose clinical management is consistent with BC clinical guideline recommendations.

   The chronic care incentive payments do not replace the fee-for-service payments GPs currently receive for providing diabetes and congestive heart failure care – the incentives are bonus payments that full service family practice physicians can claim in addition to their fee-for-service billings for the direct patient care.

3. Chronic Care Quality Improvement – Structured Collaborative Participation Funding ($1.5 million): Sessional funding (at the MSC General Practitioner rate) is available to family physicians for time spent participating in General Practice Services Committee sanctioned Structured Collaborative learning sessions.

Obstetrical care by general practitioners is a vital service, and the obstetric care incentive payment was introduced to encourage and support low-moderate volume delivery. Response to the program has been excellent, with approximately 758 general practitioners participating to date.

"The number of family physicians providing full (that is, antepartum, intrapartum and postpartum) maternity care in British Columbia has dropped dramatically in the last decade", explains Dr. Sue Harris, General Practice Service Committee. "This incentive was intended to reward those who still do attend patients and their families through this important time in their lives. Many family physicians have commented to me that the incentive represents a positive recognition for this part of their practice."

As a result of BC's aging population, family physicians are caring for more patients who have complex chronic diseases. The Chronic Care Practice Enhancement Pilot Project aims to support family physicians incorporate clinical practice strategies into their practice that will assist them in providing guideline-based care.

Response to the Chronic Care Practice Enhancement Pilot Project by Dr. David Attwell, Co-Chair, General Practice Services Committee:

"Some physicians have said to me 'the $75 fee per patient isn't worth it!' My response has been that the $75 payment is recognition that managing patients with chronic diseases entails added administrative work, effort and planning in order to do it right. This incentive payment is unique because it rewards work other than the face-to-face visit, while still paying physicians fee-for-service for their direct patient care.

It's not just about the payment – it's about 'doing the right thing' – that is, providing patients with the best and most comprehensive care possible. Many physicians have expressed their appreciation for this incentive program because prior to its launch they

felt that they were providing the best care possible, but when they reviewed their records against the flow sheets they discovered that many patients were not receiving appropriate follow up. They also discovered that many of their patients were not receiving the optimal treatment recommended in the clinical guidelines.

Physicians tell me they have appreciated the opportunity and the financial recognition of the work needed to update the care of their patients with diabetes and congestive heart failure. In addition, they have told me that they feel that participating in the incentive program has been very satisfying professionally."

As of April 15, 2004, 1502 general practitioners have participated in the Chronic Care Practice Enhancement Pilot Project.

Number of Practitioners
providing a 13050 Service –
Annual Chronic Care Incentive Bonus
September 1, 2003 — April 15, 2004

Number of payments	Number of Doctors
up to 5	264
6 to 10	166
11 to 20	248
21 to 30	164
31 to 50	263
51 to 100	318
101 to 150	59
151 to 200	17
201 to 300	3
Total	**1502**

Funding to help support family physicians participate in chronic care quality improvement Structured Collaboratives has been awarded to the Provincial Congestive Heart Failure Collaborative (sponsored by the Health Heart Society of BC), the BC Diabetes Collaborative (led by the BC Medical Associations), and the Vancouver Island Healthy Authority's, Chronic Disease Collaborative. "Response to the BC Diabetes Collaborative has been excellent", comments Dr. Dan MacCarthy, Collaborative Co-Director. "Approximately, 85 physician-led teams from across the province are participating in this professional development opportunity on re-designing clinical workflow for optimal diabetes care."

The Full Service Family Practice Incentive Program is being evaluated under the direction of the General Practice Services Committee (which has representation of the BC Ministry of Health Services, BC Medical Association, and the Society of General Practitioners of BC). The evaluation will include analysis of administrative data, and may include practitioner and patient surveys. Preliminary results will be reported as they become available.

For more information on how to participate in the Full Service Family Practice Incentive Program:

E-mail
Hlth.cdm@gems1.gov.bc.ca

Web site
http://www.healthservices.gov.bc.ca/cdm/practitioners/fullservice.html

Telephone 250 952-3124
Fax 250 952-3486

Common Drug Review Process

In September 2002, federal, provincial and territorial (F/T/P) health ministers approved a permanent Common Drug Review (CDR) process to be housed at the CDR Directorate of the Canadian Coordinating Office for Health Technology Assessment (CCOHTA).

The CDR, managed and overseen by the CDR Directorate, provides a single process for the review of new drugs and provides listing recommendations to participating publicly funded federal, provincial and territorial drug benefit plans in Canada. The CDR Directorate began accepting manufacturer submissions for new chemical entities (NCEs) and new combination products on September 1, 2003.

As part of CCOHTA, the CDR Directorate reports to the CCOHTA Board which in turn reports to the F/P/T Conference of Deputy Ministers of Health.

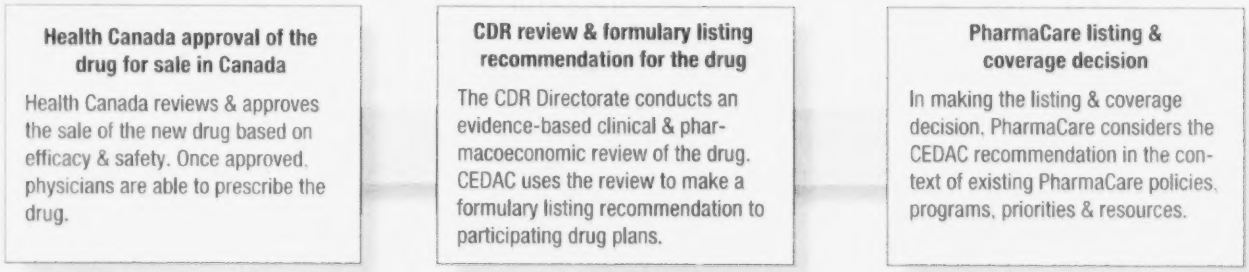
The CDR consists of:

- A critical appraisal of the best available clinical and pharmacoeconomic evidence on new drugs. Clinical and pharmacoeconomic reviews are prepared by expert scientific reviewers, based on material submitted by manufacturers and studies identified through independent, systematic literature searches.
- A listing recommendation made by the Canadian Expert Drug Advisory Committee (CEDAC). CEDAC, an appointed national independent body of physicians, pharmacists and other professionals, uses the clinical and pharmacoeconomic reviews to make common formulary listing recommendations to participating F/P/T drug plans.

The CDR's objectives are to:

- Provide a consistent and rigorous approach to the review of new drugs;
- Provide evidence-based listing recommendations;
- Reduce duplication of effort by participating drug plans;
- Maximize the use of resources and expertise; and,
- Provide equal access to the same high level of evidence and expert advice for the participating drug plans.

CEDAC recommendations are an important and valued addition to the information that participating drug benefit plans, such as PharmaCare, consider when making listing and coverage decisions regarding new drugs.


Health Canada approval of the drug for sale in Canada
Health Canada reviews & approves the sale of the new drug based on efficacy & safety. Once approved, physicians are able to prescribe the drug.
CDR review & formulary listing recommendation for the drug
The CDR Directorate conducts an evidence-based clinical & pharmacoeconomic review of the drug. CEDAC uses the review to make a formulary listing recommendation to participating drug plans.
PharmaCare listing & coverage decision
In making the listing & coverage decision, PharmaCare considers the CEDAC recommendation in the context of existing PharmaCare policies, programs, priorities & resources.

CEDAC is chaired by Dr. Andreas Laupacis. Dr. Laupacis, a general internist at Sunny Brook & Women's College Health Sciences Centre in Toronto, is currently President and Chief Executive Officer of the Institute for Clinical Evaluative Sciences and a Professor in the Departments of Medicine and Health Policy Management & Evaluation at the University of Toronto.

CEDAC Co-Chair is Dr. John M. Conly. Dr. Conly, an infectious disease specialist, is currently the Head of the Department of Medicine for the Calgary Health Region and University of Calgary; Director of the Centre for Antimicrobial Resistance at the University of Calgary; and a Professor in the Department of Pathology & Laboratory Medicine, Medicine and Microbiology & Infectious Diseases.

CEDAC Members

Dr. Ken Bassett (British Columbia) – Senior medical consultant at UBC Health Services & Policy Research; Associate Professor in the Departments of Family Practice, Pharmacology and Therapeutics, Health Care & Epidemiology & Opthalmology.

Dr. Bruce Carleton (British Columbia) – Associate Professor and Chair, Division of Clinical Pharmacy at the Faculty of Pharmaceutical Sciences, University of British Columbia; Director, Pharmaceutical Outcomes Programs at Children's & Women's Health Centre of BC; and, Clinical Scientist for the Centre for Healthcare Innovation & Improvement at the BC Research Institute for Children's & Women's Health.

Dr. Margot J. Burnell (New Brunswick) – Medical oncologist at the Department of Oncology and Department of Internal Medicine at the Atlantic Health Sciences Corporation in New Brunswick; Chair of the Pharmacy & Therapeutics Committee of the Atlantic Health Sciences Corporation.

Dr. Michael Evans (Ontario) –Family physician working at the Toronto Western Hospital. Dr. Evans holds a cross-appointment to the University of Toronto as an Assistant Professor, Department of Family & Community Medicine. Dr. Evans is also Director of the "Mini-Med School" at the University of Toronto, focusing on patient education and self-management.

Dr. Anne Holbrook (Ontario) – A clinical pharmacologist and internal medicine specialist, with expertise in pharmacoepidemiology, at the Centre for Evaluation of Medicines, St. Joseph's Hospital and the Hamilton Health Sciences Corporation in Hamilton. Dr. Holbrook is also an Associate Professor and Director, Division of Clinical Pharmacology & Therapeutics in the Department of Medicine at McMaster University.

Dr. Laurie Mallery (Nova Scotia) – Acting Head, Division of Geriatric Medicine at Dalhousie University and Acting Director, Centre for Health Care of the Elderly, Queen Elizabeth II Health Sciences Centre in Halifax. Dr. Mallery is a geriatrician who has been involved in the Nova Scotia Formulary Management Committee since 1993 and has served as Chair since 2000.

Dr. Braden Manns (Alberta) – A nephrologist on staff at the University of Calgary in the Departments of Medicine and Community Health Sciences. Dr. Manns has a Masters in Health Economics from York University in England and has served as a member of the Expert Drug Evaluation & Therapeutics Committee for Alberta Health & Wellness and of the Pharmacy & Therapeutics Committee for the Calgary Health Region since 2001.

Dr. Tom Paton (Ontario) – Director, Department of Pharmacy at Sunnybrook & Women's College Health Sciences Centre in Toronto; Associate Professor of Pharmacy, Faculty of Pharmacy and Associate Professor, Department of Medicine & Clinical Pharmacology, Faculty of Medicine, University of Toronto.

Dr. Dale Quest (Saskatchewan) – Associate Member of the College of Medicine/Pharmacology and the College of Dentistry/Biological, Diagnostic & Surgical Sciences and Associate Professor in the College of Nursing at the University of Saskatchewan. Dr. Quest is also currently Chair of Saskatchewan's Drug Quality Assessment Committee and a member of the Saskatchewan Formulary Committee.

For information about CDR visit the CCOHTA Web site: www.ccohta.ca or
e-mail the CDR Directorate: cdr@ccohta.ca.
For specific information contact:
Elaine MacPhail, Senior Pharmacist, CDR Directorate,
Telephone: 613-226-2553 ext. 245;
e-mail: elainem@ccohta.ca.

Special Authority Request Inventory Cleared

In 2003, PharmaCare Special Authority staff worked diligently to clear a substantial inventory of pending Special Authority requests. By November 2003, staff had decreased the number of requests awaiting processing by 75%, bringing inventory back to normal levels.
The majority of PharmaCare's 3400 weekly requests are being processed within targeted timelines. The timeline for uncomplicated requests is: 1 business day for urgent requests, 2 business days for priority requests and 10 business days for regular requests.

Further enhancements to the Special Authority process should result in additional streamlining and improved response times.

List of Inserts

1. Update to the MSC Payment Schedule
2. Revised Standard Out-patient laboratory Requisition (form)
3. Non-Nominal HIV Testing and Reporting (letter)
4. Full Service Family Practice Incentive Program – Frequently Asked Questions
5. CDM Toolkit
6. MSC Communiqué

Identification of Prescribing Physician – PharmaCare

PharmaCare Operations receives nearly 7,000 calls per month from pharmacies attempting to verify the College of Physician and Surgeons Identity Number (CPSID) for prescribing physicians. It appears that, in many instances, physicians are using their MSP billing/payment number instead of their CPSID.

There is concern that the wrong CPSID is being used against a prescription when it is added to a patient's medication history.

The following is an excerpt from the College Quarterly issued in the summer of 2000:

"The identity of the prescribing physician is particularly difficult to detect when a generic pad is used in a walk-in clinic, D and T Centre, or hospital emergency department, or when a locum physician utilizes the prescription pad of the physician he/she is replacing.

The Council would remind the membership that the requirement for legibility is clearly spelled out under the Medical Practitioners Act and also of the previous recommendation of Council that personalized prescription pads should have the physician's College of Physician and Surgeons identity number (CPSID) printed on them. If a generic prescription pad is used, then the prescribing physician could be identified utilizing a personalized self-inking stamp that would include the CPSID number.

In an attempt to address this ongoing problem, Council has passed the following Resolution:
RESOLUTION

00-54 RESOLVED that by September 1, 2000, all prescriptions written by members of the College be identified by their CPSID number."

Physicians can help reduce the risks associated with the wrong CPSID number being recorded in patients' medication histories by ensuring that their correct CPSID is legible on all their prescriptions.

BRITISH COLUMBIA **Ministry of Health Services**

Update to the Medical Services Commission Payment Schedule

General Practice

Amendment

The following note is hereby appended to fee item 00109:

iv) See the Physician's Resource Manual for additional billing examples.

Effective December 15, 2002 the payment rate of the following listing is amended as follows:

00043	Anticoagulation therapy by telephone	$3.40

Amendment

The following items are added to the list of items eligible for a Minor Tray Service Fee. In addition the following notes are added as indicated:

00762	Scratch test, per antigen *Note: Minor tray fee may be paid in addition if a minimum of 16 antigens are used*
00763	Scratch test - children under 5 years of age, per antigen *Note: Minor tray fee may be paid in addition if a minimum of 14 antigens are used*
00765	Annual maximum (to include scratch or intracutaneous tests) for each physician - per patient

The following item is hereby removed from the list of items eligible for a Major Tray Service Fee:

00792	Cysto-ureterogram - technical fee

The following item is hereby added to the list of items eligible for a Major Tray Service Fee when done in conjunction with a voiding cysto-urethrogram (fee item 08599)

00732	Voiding cysto-urethrogram - procedural fee

Effective December 19, 2003 the following item is added to the list of items eligible for a Major Tray Service fee:

77390	Removal of haemodialysis shunt

Ophthalmology

New Fee Items

The following items have been approved on a provisional basis until June 30, 2004, or when replaced by a subsequent Minute whichever occurs first:

Computerized retinal nerve fibre layer photography and neuro-retinal rim assessment (e.g.: Heidelberg, GDX)

P22068	- professional fee	$12.28

P22069	- technical fee	$51.64

Notes:

i) Requires both qualitative and quantitative assessments

ii) Includes examination of both eyes whether at one time or two separate visits

iii) Recommended frequency depends on the patient's clinical circumstances but cannot be billed at intervals less than 180 days without written justification.

This item is effective immediately on a provisional basis until December 31, 2005 or when replaced by a subsequent Minute, whichever occurs first:

P22125	Photodynamic therapy for age-related wet macular degeneration – professional fee	$274.39

Note: Payable to Retinal Physicians certified in PDT treatment only.

Internal Medicine

Amendment

Effective January 1, 2004 the cancellation date of the following provisional items has been extended until December 31, 2004, or when replaced by a subsequent Minute, whichever occurs first:

Patient Activated Cardiac Event Recorders

P00362	Event/unmonitored loop recorders (first strip) - Professional fee	$35.52
P00369	- each additional strip (per strip)	$17.76

Note: Additional Strips are limited to two extra strips per patient, per two-week period.

P00392	Event/unmonitored loop recorder - Technical fee	$42.68

Notes:

i. The following notes apply to fee items 00362, 00369, 00392

ii. These items are intended to cover a two-week period

iii. Consultation not paid in addition

iv. Provide note record when more than one recording billed per patient, per year.

v. Holter monitor not payable in addition

vi. *An explanatory note is required for second test, same patient*

Paediatrics

Amendment

Effective December 15, 2002 the payment rates of the following listings have been adjusted as indicated:

00511	Consultation for complex behavioural, developmental or psychiatric condition in a child	$320.65
00507	Subsequent office visit	$48.86
00508	Subsequent hospital visit	$38.64

Vascular Surgery

Amendment

The cancellation date of the following provisional item has been extended until September 30, 2004 or when replaced by a subsequent Minute, whichever occurs first:

P77177	Abdominal aortic aneurysm repair using endovascular stent graft - vascular surgery component	$1,056.08 Anaes. Level 9

Note: In order to bill P77177, vascular surgeon must be present throughout the entire procedure.

Laboratory Medicine

Amendment

The cancellation date of the following provisional item has been extended until December 31, 2004 or when replaced by a subsequent Minute, whichever occurs first:

P91719	Glucose - 2 hr, post - 75 g *Note: i) Restricted to Category IIC and Category III laboratories.*	$19.76

The cancellation date of the following provisional item has been extended until September 30, 2004 or when replaced by a subsequent Minute, whichever occurs first:

P91760**	Helicobacter pylori Carbon 13 urea breath test	$59.99

The cancellation date of the following provisional item has been extended. This Minute will expire on September 30, 2004 or when replaced by a subsequent Minute whichever occurs first:

P92355	Troponin	$30.77

The cancellation date of the following provisional item has been extended until September 30, 2004 or when replaced by a subsequent Minute, whichever occurs first:

P95053	Thallium body imaging *Notes:* *i) Not payable with 09806, 09817, 09854 or 09826* *ii) 09877 payable in addition if the patient is brought back for additional imaging the same or next day.*	$374.11

Extensions:

The cancellation dates of the following provisional items have been extended. This Minute will expire on December 31, 2004 or when the Laboratory Reform policy takes effect, whichever occurs first:

Haematology:

P90027***	Activated Protein C Resistance (APCR)	$51.88
P90036**	Antiphosphatidylserine (IgG)	$30.03
P90037**	Antiphosphatidylserine (IgM) *Note: When both P90036 and P90037 performed on same specimen, second test is billable at $22.38.*	$30.03
P90038***	Anti Saccharomyces Cerevisiae (ASCA) - IgA	$31.50
P90039***	Anti Saccharomyces Cerevisiae (ASCA) - IgG *Note: When both P90038 and P90039 are performed on same specimen, second test is billable at $25.11.*	$31.50
P90042***	Anti-Xa Heparin assay	$115.01
P90045**	Bone marrow examination *Note: 90045 includes 90465, 90490, 90205, 90340 and 90210*	$265.97

P90055***	Circulating inhibitor screen - unincubated simple mixing study	$37.32
P90065	Cold agglutinins - qualitative	$17.69
P90072**	Collagen Binding assay *Note: Not billable with 90505.*	$64.17
P90073**	Dilute Russell Viper Venom Time	$31.33
P90075**	Differential cell count on body fluids other than blood	$12.72
P90080	Direct antiglobulin (Coombs') test, polyspecific	$30.36
P90095**	Erythropoietin (EPO) assay	$36.08
P90127***	Factor V Leiden / PGM - 1st gene *Notes:* *i. Restricted to Royal Columbian, Vancouver and Victoria General Hospitals* *ii. Not billable for screening purposes* *iii. Applicable to patients with thrombophilia*	$95.12
P90128***	Factor V Leiden / PGM - 2nd gene *Notes:* *i. Billable only when performed with P90127* *ii. Restricted to Royal Columbian, Vancouver & Victoria Gen Hospitals*	$60.01
P90185	Glucose-6-phosphate dehydrogenase (G-6-PD) screening test	$21.35
P90240**	Haemoglobin electrophoresis	$38.60
P90290**	Immunophenotyping by flow cytometry - peripheral blood and/or tissue and/or bone marrow and/or body fluids - 5 tube panel	$266.23
P90335**	Malaria and other parasites	$23.20
P90340**	Marrow films for interpretation	$195.16
P90357	Neutrophil Oxidative Burst Assay	$137.83
P90360**	Nitro blue tetrazolium test	$37.21
P90377**	Phospholipid Neutralization Test - for confirmation of Lupus Anticoagulant	$52.25
P90390**	Platelet antibodies	$42.11
P90400	Platelet estimation on film	$5.67
P90427**	Protein S Activity (clot-based) *Note: Not billable with 90435 or 90430*	$46.82
P90440	Prothrombin time/INR	$14.89
P90460+	RBC antibody detection, per tube (albumin, enzyme or other antibody enhancement, e.g. LISS additive)	$8.44
P90465	RBC morphology including platelet estimation	$8.44
P90470	Red cell folate	$39.74
P90510+	Saline tubes (per tube)	$9.28
P90525	Sickle cell identification	$30.90
P90530***	Stypven prothrombin time	$34.57
P90560***	Von Willebrand's multimer analysis by autoradiography	$108.49
P91160**	Antimyeloperoxidase Ab	$31.82
P91355	Cells, count - CSF and other fluids	$36.01

Microbiology:

P90605**	Anaerobic culture investigation	$14.55
P90610***	Smear for inclusion bodies	$40.23
P90615**	Antibiotic susceptibility test, semi-quantitative per organism	$19.24
P90620	Biochemical identification of micro-organism- per organism	$11.80
P90625**	Blood culture, using aerobic and/or anaerobic media	$42.99
P90651	Chlamydia trachomatis using NAT - urine	$32.99

P90652	Chlamydia trachomatis using NAT - urogenital swab	$32.06
P90665**	Fungus culture	$16.73
P90730	Smear for inclusion bodies	$15.05
P90740	Stained smear	$7.25
P90750	Biochemical identification of micro-organism in stool	$14.21
P90780**	Throat or nose culture - each additional culture	$6.18
P90785	Trichomonas and/or candida, direct examination	$5.49
P90795	Examination for pinworm ova	$5.76
P90815	Serological tests - 1 to 3 antigens	$31.23
P90820	Serological tests - 4 or more antigens *Note: Not to be billed for any virology testing where specific listings exist (e.g.: Hepatitis).*	$46.41
P90825***	Smear or section for electron microscopy	$33.98
P90830	Virus isolation	$55.82

Chemistry:

P91023**	Acetyl CoA: a-glucosaminide-N-acetyl transferase, white blood cells *Note: Restricted to BC Children's Hospital.*	$114.53
P91027**	Acid Lipase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91036***	ACTH stimulation test	$53.27
P91037**	Acylcarnitine profiling *Note: Restricted to BC Children's Hospital.*	$50.45
P91096**	Alpha-iduronidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91097**	Alpha-mannosidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91120***	Amniotic fluid, bilirubin scan	$64.89
P91142**	Anti-diuretic hormone (ADH), plasma	$111.26
P91155*	Antiglomerular basement membrane antibody	$31.82
P91162	Anti-tissue transglutaminase antibodies (anti-TTG), IgA *Note: Not billable with 91800.*	$29.90
P91180***	Apoprotein E genotyping	$75.55
P91231**	Beta-glucuronidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91232**	Beta-mannosidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91330	Calculus analysis - urine	$34.45
P91380**	Cholinesterase with dibucaine number	$37.00
P91386***	Chromatography - keto acids	$44.38
P91387***	Chromatography - reducing substances-urine	$38.37
P91388***	Chromatography - thin layer (T.L.C.)	$39.91
P91395	Complement, total haemolytic (CH 100)	$54.04
P91480	Acetazolamide	$56.86
P91484	Amikacin	$56.86

P91486	Amiodarone	$56.86
P91490	Amoxapine	$56.86
P91492	Chlorpromazine	$56.86
P91496	Clobazam	$60.89
P91498	Clomipramine	$60.89
P91500	Clonazepam	$56.86
P91508	Desmethylclobazam	$56.86
P91510*	Diazepam	$56.86
P91512	Disopyramide	$56.86
P91514	Doxepin	$56.86
P91516	Fluoxetine	$56.86
P91518	Flupenthixol	$56.86
P91520	Fluphenazine	$56.86
P91522	Fluvoxamine	$56.86
P91526	Haloperidol	$56.86
P91528	Imipramine	$56.86
P91530	Lidocaine	$54.66
P91532*	Lorazepam	$56.86
P91534	Loxapine	$56.86
P91536	Maprotiline	$56.86
P91538	Methotrexate	$56.25
P91540	Methotrimeprazine	$56.86
P91542	Methylphenidate	$56.86
P91544	N-Acetyl procainamide	$56.86
P91546	Netilmicin	$56.86
P91548	Nitrazepam	$56.86
P91552	Paroxetine	$56.86
P91554	Perphenazine	$56.86
P91556	Procainamide	$56.86
P91558	Propranolol	$56.25
P91560*	Sertraline	$56.86
P91562	Thioridazine	$56.86
P91566	Trazodone	$56.86
P91568	Trifluoperazine	$56.86
P91570	Trimipramine	$56.86
P91601**	Electrophoresis - protein, quantitative	$33.25
P91602**	Electrophoresis - C.S.F	$38.59
P91680	Gastric analysis, intubation	$22.17
P91715***	Glucose quantitative, 2 to 5 hours	$36.65
P91717**	Glucose quantitative - intravenous	$47.54
P91730	Glutathione peroxidase	$52.20
P91762**	Heparan sulfamidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$114.53
P91777**	Hexosaminidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$114.53
P91800	IgA Anti-gliadin antibodies *Note: Applicable only to TTG negative gluten sensitive enteropathy*	$39.83
P91820***	Immunofixation - CSF	$124.04
P91850	Inclusion bodies - (cytomegalic) - urine	$9.51
P91912	Lead - prophyrin screening test - urine	$7.60
P91915***	Lecithin sphingomyelin ratio	$273.52
P91920***	LHRH stimulation test - in addition to specific tests billed	$56.48
P91940**	Lipoprotein electrophoresis	$68.49

P91970	Metachromatic granules - urine	$18.34
P91992	Mitochondrial preparation - muscle *Note: Restricted to BC Children's Hospital.*	$110.67
P91997**	N-acetyl-Galactosamine-6-sulfate sulfatase, white blood cells *Note: Restricted to BC Children's Hospital.*	$114.53
P92035	Pentagastrin test - gastric	$82.50
P92075	Pigments, abnormal, (spectroscopic)	$17.18
P92090	Porphyrins - qualitative, urine	$9.43
P92091	Porphyrins - quantitative with separation - urine	$67.63
P92095**	Porphyrins - quantitative - blood	$26.92
P92110	Pregnancy Test - Serum	$10.14
P92146	Proteins - timed urine collection	$10.96
P92156**	Pyruvate Carboxylase, Fibroblasts *Note: Restricted to BC Children's Hospital.*	$114.53
P92157**	Pyruvate Dehydrogenase, fibroblasts *Note: Restricted to BC Children's Hospital.*	$114.53
P92195**	Respiratory chain enzymes - muscle *Notes:* *i. Includes Complex 1, Complex II, Complex IV, citrate synthase* *ii. Restricted to BC Children's Hospital.*	$335.53
P92201	Salicylates, qualitative - gastric	$3.54
P92202	Salicylates, qualitative - urine	$3.67
P92320***	Thyroid Releasing Hormone (TRH) Stimulation Test *Note: Includes all time spent with patient, including injection and medication administered.*	$68.33
P92346**	Transferrin Isoelectric focusing (qualitative) *Note: Restricted to BC Children's Hospital.*	$110.59
P92353**	13C Triolein Breath Test for malabsorption *Note:* *i. Includes collection of "before" and "after" breath samples* *ii. Not billable with 91636* *Note: Restricted to BC Children's Hospital.*	$82.97
P92395	Urinalysis, microscopic	$5.89
P92430*	Vitamin A	$56.38
P92435*	Vitamin B1	$66.36
P92440*	Vitamin B2	$66.36
P92445*	Vitamin B6	$66.36
P92465	Vitamin E	$63.53
P92467	White blood cell preparation for lysosomal enzyme testing	$51.76
P92470**	Xylose tolerance	$129.72

Anatomical:

P93010	Crystal identification, synovial fluid	$41.11
P93070***	Chromosomal breakage studies	$214.10
P93085	Cytologic preparation and examination of fine needle aspirate	$112.30
P93090	Cytologic preparation and interpretation of pre-screened, non-gynaecological cytology	$78.10

P93095	Cytologic preparation and interpretation of unscreened, non-gynaecological cytology	$101.90
P93100*	Electron microscopy fee	$458.06

Nuclear Medicine:

P09817	Receptor Imaging - Isolated Procedure	$235.77
P09826	Tumour imaging - isolated procedure	$1265.13
P09870	Ocular tumour localization	$164.92
P09871	Brain scan - regional cerebral blood flow (isolated procedure)	$239.95
P09880	Treatment for hyperthyroidism or cardiac disease - charge per course of treatment (Iodine therapy)	$205.41
P09881	Treatment for polycythaemia vera with P32 - charge per course of treatment	$205.41
P09883	Treatment for prostate cancer - charge per course of treatment	$414.88
P09884	Treatment for metastatic carcinoma of bone - charge per course of treatment	$269.74
P09885	Treatment for ascites and/or pleural effusion, malignant	$403.91
P09898	Coronary perfusion with radio particles, per radionuclide	$175.74

Medical Microbiology:

P94005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums)	$104.76
P94010	Consultation: to consist of examination, review of history and laboratory findings with a written report	$117.83
P94012	Repeat or limited consultation: where a consultation for same illness is repeated within six (6) months of the last visit by the consultant or where, in the judgement of the consultant, the consultative service does not warrant a full consultative fee	$65.47
P94006	Directive care	$26.19
P94007	Subsequent office visit	$26.19
P94008	Subsequent hospital visit	$26.19
P94009	Subsequent home visit	$52.43

The cancellation date of the following provisional items has been extended until September 30, 2004 or when replaced by a subsequent Minute whichever occurs first:

Drugs of Abuse Testing - Screening Assays:

P92510	Methadone Metabolite	$4.33
P92513	Methadone	$4.33

Drugs of Abuse - Confirmatory and Specific Quantitative Assay Testing:

P92515*	Blood Methadone	$56.73

Nuclear Medicine

The cancellation date of the following provisional item has been extended until September 30, 2004, or when replaced by a subsequent Minute whichever occurs first:

P95012	Helicobacter pylori Carbon 14 urea breath test	$104.14

STANDARD OUT-PATIENT LABORATORY REQUISITION

1901

LABORATORY ADDRESS

LAB USE ONLY

BILLABLE TO
☐ MSP ☐ ICBC ☐ WCB ☐ PATIENT ☐ OTHER

NAME OF PHYSICIAN & MSP PRACTITIONER NUMBER (or office stamp)

PERSONAL HEALTH NUMBER

DOB: YYYY / MM / DD

SURNAME OF PATIENT

FIRST NAME AND MIDDLE INITIAL

TELEPHONE # (INCLUDE AREA CODE)

GENDER ☐ M ☐ F

PREGNANT ☐ Yes ☐ No

ADDRESS

CITY/TOWN

POSTAL CODE

COPY RESULTS TO

DATE & TIME OF COLLECTION

HOURS SINCE LAST MEAL

DATE & TIME LAST DOSE

PHLEBOTOMIST INITIALS

DIAGNOSIS AND INDICATIONS FOR GUIDELINE PROTOCOL AND SPECIAL TESTS

CURRENT MEDICATION

NOTE: PROVINCIAL GUIDELINES / PROTOCOLS SHOULD BE CONSULTED FOR TESTS IN ITALICS / SHADED BOXES.
www.healthservices.gov.bc.ca/msp/protoguides/

HEMATOLOGY

☐ WBC

☐ Hemoglobin ☐ Hemoglobin only

☐ Hematology profile
Includes Hb, WBC, platelets, Hct, RBC indices, and differential when indicated

☐ PT-INR

☐ *ESR - provide indication above*

CHEMISTRY

☐ Glucose - fasting

☐ GTT - Gestational diabetes screen

☐ GTT - Gestational diabetes confirmation

Pregnancy test ☐ Urine ☐ Serum

☐ Therapeutic drug concentrations

Specify drugs: _____

_____

☐ Toxicity suspected

☐ *TSH* - Provide indication above if additional thyroid test ordered.

☐ PSA MSP billable ☐ Yes ☐ No *(patient pays)*
Provide indication above

☐ *Ferritin* ☐ *Iron & transferrin saturation*
Provide indication above if ordered together

LIPIDS

Major risk factor(s) for CAD ☐ *Yes* ☐ *No (patient pays)*

☐ *Total cholesterol*

☐ *Triglycerides*

☐ *HDL-cholesterol*

☐ *LDL-cholesterol (calculated)*

INSTRUCTIONS TO PATIENTS (see reverse)
Other instructions:

MICROBIOLOGY

TEST: ☐ Bacterial culture ☐ Gram stain
(list current antibiotics above)

SITE: ☐ Nose ☐ Sputum ☐ Throat ☐ Stool

☐ Other _____

TEST: ☐ Fungus culture ☐ Fungus direct exam (KOH prep)

SITE: ☐ Skin ☐ Nails

☐ Other _____

URINALYSIS / URINE CULTURE

☐ *Macroscopic (dipstick)* ☐ *Microscopic*

☐ *Macroscopic • microscopic if dipstick positive*

☐ *Macroscopic & microscopic, provide indication above*

☐ *Urinalysis • urine culture if pyuria or nitrite present*

☐ *Urine culture (list current antibiotics above)*

GENITAL SPECIMENS

Cervicitis ☐ *Chlamydia (special swab)* ☐ *Gonorrhea*

Urethritis ☐ *Chlamydia (special swab)* ☐ *Gonorrhea*

Vaginitits ☐ *Initial (smear only)*
☐ *Recurrent/chronic (smear & culture)*
☐ *Trichomonas*

Vagino-anorectal, pregnancy ☐ *(group B strep only)*

Urine ☐ *Chlamydia*

VIRAL HEPATITIS

Note: testing will be according to the hepatitis guideline/ protocol unless specifically ordered under additional tests/ instructions

☐ *Acute* ☐ *Previous / Chronic* ☐ *B carrier*

STOOL - OVA & PARASITES

☐ *One specimen* ☐ *Two specimens (high risk)*

TELEPHONE REQUISITON TIME

INITIALS OF RECORDER

SPECIAL TESTS

☐ HIV Serology - Non-Nominal Reporting

☐ HIV Serology - Nominal Reporting

*** one box must be marked**

Patient has legal right to choose nominal or non-nominal reporting

ADDITIONAL TESTS / INSTRUCTIONS

SIGNATURE OF REQUESTING PHYSICIAN

DATE SIGNED (YYYY / MM / DD)

BRITISH COLUMBIA

February 4, 2004 485861

Practicing Physicians in BC

Dear Doctor:

Re: NON-NOMINAL HIV TESTING AND REPORTING

On April 30, 2003, HIV infection was added to Schedules A and B of the *Health Act* Communicable Disease Regulations.

The principle rationale for this change was to involve the BC public health system in the notification of partners of individuals testing newly positive for HIV. The change brought with it some additional obligations for physicians and other health care workers involved in patient counselling.

Foremost amongst these obligations was the requirement that, to consent to HIV testing, the patient *must* be informed that:

- a notification of a positive result will be sent from the provincial laboratory (BCCDC Laboratory Services) to the local medical health officer (MHO);
- patients have the right, in law, to select either nominal (with names) or non-nominal (coded) reporting; *and*
- if non-nominal reporting is chosen, the patient's identity will be withheld from the local medical health officer for routine partner follow up, unless the patient subsequently *consents* to such release or if *non-disclosure would put a third party at risk*.

In order to facilitate the implementation of the non-nominal reporting to public health, the BC Centre for Disease Control (BCCDC) requisition forms for HIV testing were altered to include a reminder to physicians about the non-nominal option, and a box for referring physicians to check, to indicate to the BCCDC whether a non-nominal option had been selected (in which case the BCCDC would not transmit patient identifiers to the local MHO).

...2

Ministry of Health Services
Office of the Provincial Health Officer
1515 Blanshard Street, 4-2
Victoria BC V8W 3C8
Tel: (250) 952-1330
Fax: (250) 952-1362
http://www.healthplanning.gov.bc.ca/pho

College of Physicians & Surgeons of BC
Deputy Registrar (Ethics)
Dr. T. Peter Seland
400-858 Beatty St
Vancouver BC V6B 1C1
Tel: (604) 733-7758
Fax: (604) 733-3503
http://www.cpsbc.ca

A review of the process at year-end 2003 has revealed two issues, which we wish to bring to your attention. Firstly, approximately 60% of positive HIV tests have been requisitioned on non-BCCDC laboratory requisition forms. Secondly, information on whether a patient has selected the non-nominal reporting option is missing from approximately 2/3 of all requisitions received by the provincial laboratory.

This lack of information means that public health staff from the provincial laboratory have to check back with the ordering physician to determine whether or not a patient selected non-nominal reporting. This is an avoidable process that involves both public health and primary care physicians in considerable unnecessary interaction and consequent delays in reporting of positive results to the public health system.

A number of measures are proposed to address this. Principally, in order to facilitate collection of the missing information, the BC laboratory network will be taking steps to have all non-BCCDC requisition forms include pertinent information relating to the non-nominal HIV test option.

However this will still not address the problem of physicians who fail to appropriately complete the forms, and who fail to notify the public health laboratory of the patient's choice nor will it address our added concerns that physicians may not be informing patients of the non-nominal option.

Accordingly the BC Provincial Health Officer and the College of Physicians and Surgeons of BC have drafted this bulletin to update physicians in BC on the implementation of HIV reportability and to bring to their attention:

- the requirement for physicians to address non-nominal reporting with their patients as an essential component of the patient's informed consent for HIV testing; and
- the responsibility that physicians have for clearly noting the choice made on the HIV test requisition, so that the public health authorities can follow up in a manner that is consistent with the provisions of the *Health Act* and that respects the patient's legally-sanctioned choice.

Concerns and questions around this issue may be addressed to Dr. Perry Kendall, Provincial Health Officer or Dr. Peter Seland, Deputy Registrar, College of Physicians and Surgeons of BC.

Sincerely,

P. R. W. Kendall
MBBS, MSc, FRCPC
Provincial Health Officer

Dr. T. Peter Seland
Deputy Registrar
College of Physicians and Surgeons of BC

Full Service Family Practice Incentive Program

Frequently Asked Questions

(Revised: April 27, 2004)

GENERAL PRACTITIONER OBSTETRICAL CARE INCENTIVE

1. **How much money has been allocated to this program?**

   $3.0 million has been provided for this incentive.

2. **When I submit a claim for the bonus payment on fee items 14104 or 14109, what is the exact amount of the payment?**

   The obstetrical care bonus payment is:
   - $258.33 for fee item 14104
   - $215.17 for fee item 14109

3. **How is the bonus billed?**

   In addition to billing either 14104 (Delivery and post-natal care) or 14109 (Delivery and post-natal care associated with emergency caesarean section), fee code 14000 and the appropriate three-digit ICD-9 code must be billed in order to receive the bonus. This bonus is only payable to family physicians that perform only a single delivery on any one day. There is a maximum of one bonus per patient delivered each day, up to a maximum of 25 bonuses per physician (i.e., per physician number) per calendar year.

4. **How many may I bill in calendar 2003?**

   You may bill for up to 25 deliveries in 2003, but only deliveries on or after September 1, 2003 are eligible.

5. **Are locums able to bill this bonus?**

   Yes. Locum coverage is considered part of the usual care provided by the host general practitioner. There is a maximum of one bonus per patient delivered each day, up to a maximum of 25 bonuses per physician number.

6. **In practice situations where a patients' care may be shared amongst partners, is the bonus still applicable? Who bills it?**

   The physician performing the delivery may bill fee item 14000. Practice groups providing on-call patient coverage or access to patient records are considered to be sharing the responsibility of that patients' care and are eligible to bill the bonus.

7. **If a GP refers a patient to me for only the delivery, am I eligible to bill the bonus?**

   Yes. General Practitioners specializing in general practice/obstetrics who receive referrals from other GPs are eligible for this bonus, even if the patient returns to the referring GP after the postpartum care.

8. **Is the bonus billable if a delivery is performed during an on-call shift for a partner's patient?**

   Yes. This is considered shared care.

9. **How is the bonus applied to multiple births?**

   Multiple births are considered one delivery, and thus eligible for one bonus.

10. **Can I bill for delivering mothers covered by other provinces?**

    Yes. Treat patients from other provinces who have their babies in BC as though they were BC residents.

11. **Can I still bill the payment if another doctor helps me with complications?**

    As long as you attend the delivery of the baby (or are prepared to until the need for an emergency section)you may bill the payment. If another doctor helps by performing a forceps rotation, emergency c-section, or other additional procedure you are still eligible.

STRUCTURED COLLABORATIVE PARTICIPATION FUNDING

1. **How much money has been allocated to this program?**

   $1.5 million has been allocated.

2. **How do I enroll in a Structured Collaborative?**

   Physicians will be notified when an approved collaborative is being started through a number of media (e.g. BCMA President's Letter, email, fax, and website posting). Participation requests will be considered at that time.

3. **Will participation in a Structured Collaborative be remunerated?**

   Yes. The organization sponsoring the structured collaborative will be responsible for remunerating physicians. Remuneration for time spent at learning sessions will be equivalent to the current general practitioner sessional rate.

CHRONIC CARE PRACTICE ENHANCEMENT INCENTIVE

1. **How much money has been allocated to this program?**

   $15.5 million has been allocated.

2. **Will payment item 13050 replace the usual visit fees for those patients who have chronic conditions?**

   No. Billing for office visits should continue as usual. This bonus is intended to be billed in addition to any other fees incurred by usual patient care. It is a management bonus, intended to compensate for the time taken to maintain patient care plans in accordance with the BC clinical guidelines.

3. **Do I have to see the patient to bill the payment?**

   You will have to see the patient to provide care according to the guidelines, but you do not have to see the patient to fill in the flow sheet. Doctors who have been providing care according to the guidelines may be able to complete the first columns of the flow sheet from their records.

4. **Can I still bill if the patient is in a long term care facility?**

   Patients in long term care facilities are eligible, however clinical judgment may be needed about the appropriateness of following the diabetes guideline in patients with dementia or very limited life expectancy.

5. **Where can I find the clinical guidelines?**

   Both the Diabetes Care and Heart Failure Care guidelines are found on the Guidelines and Protocols page of the Medical Services Plan website: http://www.hlth.gov.bc.ca/cdm/index.html. A link is provided on the BCMA website (www.bcma.org).

6. **Where can I obtain a copy of the flow sheets?**

   The Full Service Family Practice Incentive Program guidebook includes copies of the flow sheets. The guidebook can be found on the British Columbia Medical Association website (www.bcma.org) or the Chronic Disease Management page of the Medical Services Plan website (http://www.hlth.gov.bc.ca/cdm/index.html).

7. **Will other flow sheets be admissible for the bonus?**

   Other flow sheets can be used if they are consistent with the BC clinical guidelines for diabetes and/or heart failure management and contain the same information included in the flow sheets provided by the program. Physicians are not required to submit the completed flow sheets to the Ministry of Health Services in order to receive the incentive payment. Instead, this program will be subject to random audit. Therefore, it is important that you keep all of your completed patient flow sheets on file.

8. When should the incentive bonus be billed?

Fee item 13050 may be billed once continuity of monitoring the patients' course of care according to BC Clinical Guidelines has been established. This is considered to be established once the minimum requirements outlined below have been completed. Flow sheets may be completed retroactively if criteria have been met, and the fee may be billed as of September 1, 2003.

Congestive Heart Failure Care Flow Sheet

- Fee item 13050 may be billed once the Goals Column, Initial Review (Baseline) Column, and subsequent column (visit intervals determined by physician) have been completed.
- In the case of the death of a patient following establishment of Goals and Initial Review (Baseline) columns without subsequent updates, the administering physician may still bill the incentive bonus.

Diabetes Patient Care Flow Sheet

- Fee item 13050 may be billed after 2 columns of the flow sheet have been completed.

9. Can I bill the payment even if the care objectives are not met?

You can bill the payments as described under question 7 even if the patients' condition does not meet care objectives – such as a blood pressure below or equal to 130/80.

10. Is it possible to claim for both flow sheets?

If a patient has both diabetes mellitus and congestive heart failure, and criteria are met for each condition, two annual incentive bonuses may be billed separately.

11. Can I bill for patients covered by other provinces?

No, patients covered by other provinces who are temporarily in BC are not eligible as their regular physician is in the other province. If they stay in BC and obtain coverage under the Medical Services Plan then they become eligible for the program.

Chronic Disease Management (CDM) Toolkit for Practitioners

In response to BC physician requests for an information technology solution for efficient organization and retrieval of their chronic care patient information, the BC Ministry of Health Services is pleased to announce the launch of the CDM Toolkit. This web-based technology provides a host of functions to support optimal chronic disease management. The new CDM Toolkit is useful especially for practices that do not have an electronic medical record system.

What is the CDM Toolkit?

The CDM Toolkit is an expansion of the Ministry of Health Service's *Secure Web site for Practitioners* where BC physicians can access a probabilistic list of patients with chronic conditions, such as congestive heart failure, diabetes, asthma and hypertension. It also reports on the extent to which the care provided is consistent with BC Clinical Guidelines.

The addition of the CDM Toolkit enables practitioners to:

1. Electronically access BC Clinical Practice *Guidelines and Protocols* developed by the MSP/BCMA Guidelines and Protocols Advisory Committee

2. Electronically complete patient flow sheets

3. Automatically generate the following clinical and administrative reports, based on patient flow sheet data:

    - *Patient Profile Reports* that compile all of a patient's chronic care information into a single record that can be printed and maintained in the patient's chart. Aggregation of information on different chronic diseases enables easy access to patient co-morbidity information, and eliminates double entry of patient information.

    - *Practice Profiles* that provide age/gender information on patients with specific chronic diseases for a given practice.

    - *Recall Reports* that list the practice's patients who should be scheduled for their next office visit. These reports also specify required tests or procedures, according to evidence-based BC clinical practice *Guidelines and Protocols*.

    - *Run Charts* that graph changes in the practice's clinical processes and patient health outcomes over a period of time.

    - *Patient Education Records* that give patients valuable information on their chronic disease, along with a graph of their progress over time on health indicators (e.g., A1C levels; blood pressure).

    - *Data Extremes Reports* that enable the practitioner to identify patients who fall below the practice average on disease-relevant clinical process and health outcome measures.

4. To coordinate care, share patient flow sheets with the group practice, practice network or specialists via secure Internet data transfer.

What other functions will be added to the CDM Toolkit in the next few months?

Physicians will be able to transfer electronically consult notes and referral letters to one another to ensure continuity of patient care. Toolkit connectivity with PDAs will also be available.

How does the CDM Toolkit support BC chronic disease management quality improvement structured collaboratives?

You will be able to compare your patient run charts with the aggregate data run charts of other practitioners on your team, and of all practice teams participating in the Collaborative.

What software will I need?

All you need is Internet access (high speed Internet is recommended) and a current Web browser (Internet Explorer v6.0 or higher is recommended). Adobe Acrobat Reader is required to open reports generated in pdf format. If you do not have a current version of Adobe Acrobat, version 5.0 or higher, installed on your computer, you may download it for free at http://www.adobe.com/products/acrobat/readstep2.html.

Although not required, you may find MS Word and MS Excel useful for reviewing documents.

Does the CDM Toolkit interface with electronic medical records (EMRs)?

If your office uses an EMR, you will be able to transfer automatically patient chronic care information from your EMR to the CDM Toolkit. Several vendors are implementing this file transfer service allowing you to use their clinical templates or flow sheets to collect patient information and to create a file for secure transmission to the CDM Toolkit.

Please contact your EMR vendor to enquire if they have implemented this service. Your vendor may contact the Ministry of Health Services Helpdesk for more information: Tel: 250-952-1234; Email: hlth.hnetconnection @gems1.gov.bc.ca.

How confidential is the data in the CDM Toolkit?

Only a physician who owns and provides patient information, and who is registered to use the CDM Toolkit can access a patient's data and reports available through the CDM Toolkit. A physician may wish to give access to members of the clinical team. The Ministry of Health Services, health authorities and collaborative administrators can run aggregate or summary reports for physicians participating in collaboratives – they do not have access to individual patient data.

How do I register to use the CDM Toolkit?

If you are a licensed BC physician registered with the BC Medical Services Plan, you can access the CDM Toolkit by registering to use the *Ministry of Health Service's Secure Web site for Practitioners* at **https://healthnet.hnet.bc.ca/has/regagree/4614fil.pdf.**

If you have already registered, the same user ID and password allows you to access the CDM Toolkit. You will receive an e-mail indicating when your user ID has been set up enabling access to the CDM Toolkit. You can log-in to the CDM Toolkit at **https://healthregistry.moh.hnet.bc.ca**

The CDM Toolkit was made possible through funding from Health Canada's Primary Health Care Transition Fund.

The CDM Toolkit was developed and tested in consultation with BC family physicians to ensure that it meets the chronic care management needs of BC practitioners and can be easily incorporated into day-to-day practice management.

MSCommuniqué

Communicating the policy and directives of the Medical Services Commission of British Columbia

Volume 9 Number 2

May 21, 2004

CMQ04-006

Approval of Guideline: Identification, Evaluation and Management of Patients with Chronic Kidney Disease

Minute of Commission 04-007

Approval of Guideline for Identification, Evaluation and Management of Patients with Chronic Kidney Disease

Pursuant to Section 5(1)(c), 24(1), and Section 37 of the *Medicare Protection Act*, the following guideline will apply with respect to the Medical Services Commission Payment Schedule:

Identification, Evaluation and Management of Patients with Chronic Kidney Disease

This guideline will be used in determination of benefits payable under the *Medicare Protection Act*.

Effective March 1, 2004

CMQ04-007

Approval of the Guideline for Diagnosis & Management of Major Depressive Disorder

Minute of Commission 04-024

Approval of the Guideline for Diagnosis and Management of Major Depressive Disorder

Pursuant to Section 5(1)(c), 24(1), and Section 37 of the *Medicare Protection Act*, the following guideline will apply with respect to the Medical Services Commission Payment Schedule:

Diagnosis and Management of Major Depressive Disorder

This guideline will be used in determination of benefits payable under the *Medicare Protection Act*.

Effective June 1, 2004

Members

Joy Illington (Chair)
Geoff Rowlands (Deputy Chair)
Anne Sutherland Boal
Bob Cronin
Dr. Marshall Dahl
Gordon Denford
George Edgson
Dr. Derryck Smith
Ben Trevino

Guidelines and protocols can be obtained by contacting MSP at 250 952-1347 or by faxing 250 952-1417. Guidelines and protocols are also posted on the MSP web site: http://www.healthservices.gov.bc.ca/msp/protoguides. Please e-mail your questions or comments to hlth.guidelines@gems6.gov.bc.ca

Medical Services Commission of British Columbia, 2-1, 1515 Blanshard Street, Victoria, BC V8W 3C8
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CMQ-04-008

Approval of the Guideline for Microscopic Hematuria (Persistent)

Minute of Commission 04-025

Approval of the Guideline for Microscopic Hematuria (Persistent)

Pursuant to Section 5(1)(c), 24(1), and Section 37 of the *Medicare Protection Act,* the following guideline will apply with respect to the Medical Services Commission Payment Schedule:

Microscopic Hematuria (Persistent)

This guideline will be used in determination of benefits payable under the *Medicare Protection Act.*

Effective June 1, 2004